

FILED 1111 21 1945
Registration District No. 311

Primary Registration District No. 4456

Registrar's No. 43

1. PLACE OF DEATH:
 (a) County St. Clair
 (b) City or town Appleton City
(If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution: _____
(If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution _____
(Specify whether years, months or days)
 In this community 28 yrs

2. USUAL RESIDENCE OF DECEASED:
 (a) State Mo (b) County St. Clair
 (c) City or town Appleton City
(If outside city or town limits, write "RURAL")
 (d) Street No. _____
(If rural, give location)
 (e) Citizen of foreign country? _____ (Yes or No)
 If yes, name country _____

3. (a) PRINT FULL NAME Louise Kathrine Schneck
 3. (b) If veteran, name war None
 3. (c) Social Security No. None

MEDICAL CERTIFICATION
 20. DATE OF DEATH: Month June day 7
 year 1945 hour 8 minute 9 M.
 21. I hereby certify that I attended the deceased from June 1
1944, to June 18, 1945;
 that I last saw her alive on June 18, 1945
 and that death occurred on the date and hour stated above.

4. Sex Female 5. Color or race White 6. (a) Single, widowed, married, divorced Widowed
 6. (b) Name of husband or wife John Schneck 6. (c) Age of husband or wife if alive 26-1868
 7. Birth date of deceased: (Month) Aug (Day) 26 (Year) 1868

Immediate cause of death: Heart failure

8. AGE:	Years	Months	Days	If less than one day
	<u>84</u>	<u>9</u>	<u>17</u>	hr. _____ min. _____

Due to Hypertension
 Due to Chronic Nephritis

9. Birthplace MO
(City, town, or county) (State or foreign country)
 10. Usual occupation Housekeeping

Other conditions (Include pregnancy within 3 months of death) _____
 Major findings: Of operations _____
 Of autopsy BW

11. Industry or business _____
 12. Name George Willig
 13. Birthplace Germany
(City, town, or county) (State or foreign country)
 14. Maiden name Miss Fuchs
 15. Birthplace Germany
(City, town, or county) (State or foreign country)

22. If death was due to external causes, fill in the following:
 (a) Accident, suicide, or homicide (specify) _____
 (b) Date of occurrence _____
 (c) Where did injury occur? _____
(City or town) (County) (State)
 (d) Did injury occur in or about home, on farm, in industrial place, in public place? _____
(Specify type of place) (a) Means of injury (1)

16. (a) Informant Percy Hill
 (b) Address Appleton City, Mo

23. Signature R L Hanson (M. D. or other) M.D.
 Address Appleton City, Mo Date signed 6-9-45

17. (a) Burial (b) Date thereof June 10, 1945
(Burial, cremation, or removal) (Month) (Day) (Year)
 (c) Place: burial or cremation Appleton City
 18. (a) Signature of funeral director Frank Tate
 (b) Address Appleton City, Mo
 19. (a) June 4-45 (b) John M. Wells
(Date received local registrar) (Registrar's signature)

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

7310

RECEIVED
District Health Officer No. 77
District File Number 6-45-698
Date Filed 7-13-45

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by ME
on June 7 - 1945, Registered Apprentice No. _____
working under my personal supervision.

Signed Frank Lee
Licensed Embalmer No. 1099
P. O. Address Appleton City

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.